

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film 6405 5/16/68
05735
05738
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Joseph S. DeCrispino			2a. DATE OF DEATH 4 Month 27 Day 68 Year			2b. HOUR 5 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-31-1909/ 1910		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Howard Md					
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 37 Greenway Dr.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant			12b. KIND OF BUSINESS OR INDUSTRY Food		
13a. USUAL RESIDENCE (Where deceased admission) STATE Md			13b. COUNTY Harford		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 37 Greenway Drive		
14. FATHER'S NAME First Middle Last Harry D. DeCrispino			15. MOTHER'S MAIDEN NAME First Middle Last Mary DelBonzo								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 213-01-7967		17. INFORMANT Address Carmello DeCrispino Same as Above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease 201X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 201X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Mid 1963, to April 27, 1968, that (I) (we) last saw the deceased alive on April 19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Morris J. Wizenberg					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 27, 1968				
22d. PHYSICIAN'S NAME (Type) Morris J. Wizenberg, M.D.					22e. ADDRESS University of Maryland Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-30-1968		23c. NAME OF CEMETERY OR CREMATORY Mt New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Balto., Md.					
24. FUNERAL DIRECTOR Wm. Cook-Brooks West 6212 Balto. Nat'l Pike					25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last KATIE ELLEN DUVALL						2a. DATE OF DEATH Month Day Year APRIL 23 1968			2b. HOUR M		
3. SEX F		4. RACE W		5. DATE OF BIRTH JULY 10 1872		6. AGE (In years last birthday) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD Md.					
10. CITY OR TOWN OF DEATH SAVAGE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 110 WASH. ST.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY HOWARD			13c. CITY OR TOWN SAVAGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 110 WASHINGTON ST	
14. FATHER'S NAME First Middle Last AUGUST POSTER				15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address ARTHUR A. DUVALL LAUREL MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X Heart debility DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Serility DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 794X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/1/68 , 19 68 , to 4/23/68 , 19 68 , that (I) (we) lost saw the deceased alive on 4/23 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frank E. Shipley				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) FRANK E. SHIPLEY, M.D.				22e. ADDRESS Savage, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-68		23c. NAME OF CEMETERY OR CREMATORY SAVAGE CEM.		23d. LOCATION (City or Town) (County) (State) SAVAGE HOWARD MD					
24. FUNERAL DIRECTOR W. W. Conner, Laurel Md.				ADDRESS		25a. REC'D BY REGISTRAR APR 30 1968		25b. REGISTRAR'S SIGNATURE J. J. Judge			

05732



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
JAMES GRADY GRIFFIN						Mated <input type="checkbox"/> April 18, 1968		11:00 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Male	White	17 AUG 1918	49 YRS	MONTHS	DAYS	HOURS	MIN.	Month April Day 18, Year 68	2d. HOUR 11:00 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
N.C.		U.S.A.				Howard				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Mt. Airy			Rt. #3, Mt. Airy, M.D.			LANDSCAPING		SURGERY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Howard		Mt. Airy				Rte. #3	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
FRANK GRIFFIN			LIZZIE JOHNSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
YES WWII						PUGH FUNERAL HOME, RANDLEMAN, N.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Gunshot wound of Heart										
985X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
919.0										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			9:00 P.M. 4-14 19 68		Shot by wife					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
		Home		Rte. #3		Mt. Airy		Howard Maryland		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE			M.D.			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			Edward F. Wilson, M.D.			4-19-68				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL/REMOVAL			APR 24, 1968		RANDOLPH MEMORIAL PARK		RANDOLPH COUNTY, N.C.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ULLRICH FUNERAL HOME, BALTO, MD.					DATE APR 24 1968		Charles Judge			

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RECEIVED - GENERAL INVESTIGATION

10-1-41

W. C. Sullivan
Franklin
Lester
London
W. C. Sullivan
Franklin
Lester
London

[Handwritten signature]

W. C. Sullivan
Franklin
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W. C. Sullivan
Franklin
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
RONALD			HOFMANN			APRIL Month 30 Day 68 Year		12:25		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
MALE		WHITE		JULY 16, 1962		5 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MARYLAND		U.S.A.				HOWARD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
ELLICOTT			107 BEECHWOOD DR.			NONE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
SAME Md.			Howard				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		107 BEECHWOOD DRIVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
RONALD HOFMANN			ELISABETH KNOPPEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			NONE		PARENTS		SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> 2730 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CYSTIC FIBROSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 2 MONTHS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 2793										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>66</u> , to <u>APRIL</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Beryl T. Rosenstein MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>5/2/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Beryl T. Rosenstein, M.D.</u>					22e. ADDRESS <u>The Johns Hopkins Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		MAY 3, 1968		CREST LAWN		HOWARD CT. MARYLAND				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
HOFFMANN FUNERAL HOME 3218 HUDSON STREET 24					MAY 6 1968		<u>Charles Judge</u>			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Route 32</u>	
3. NAME OF DECEASED (Type or print) <u>Earl Benjamin Kelly</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1912</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FT. Meade</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Thomas Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Ellen Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-1406</u>	
17. INFORMANT <u>Genevieve Hudson (daughter)</u>		Address <u>Sykesville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109 ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u> <u>2 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-11</u> , 19 <u>65</u> to <u>4-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>68</u> , and that death occurred at <u>9:55</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Peter V. Thorpe</u>		22b. DATE SIGNED <u>4-17-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>PETER V. THORPE MD.</u>		22d. ADDRESS <u>ELLCOTT CITY - MD. 21043</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-19-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Locust Meth. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Simpsonville, Md</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Rockville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

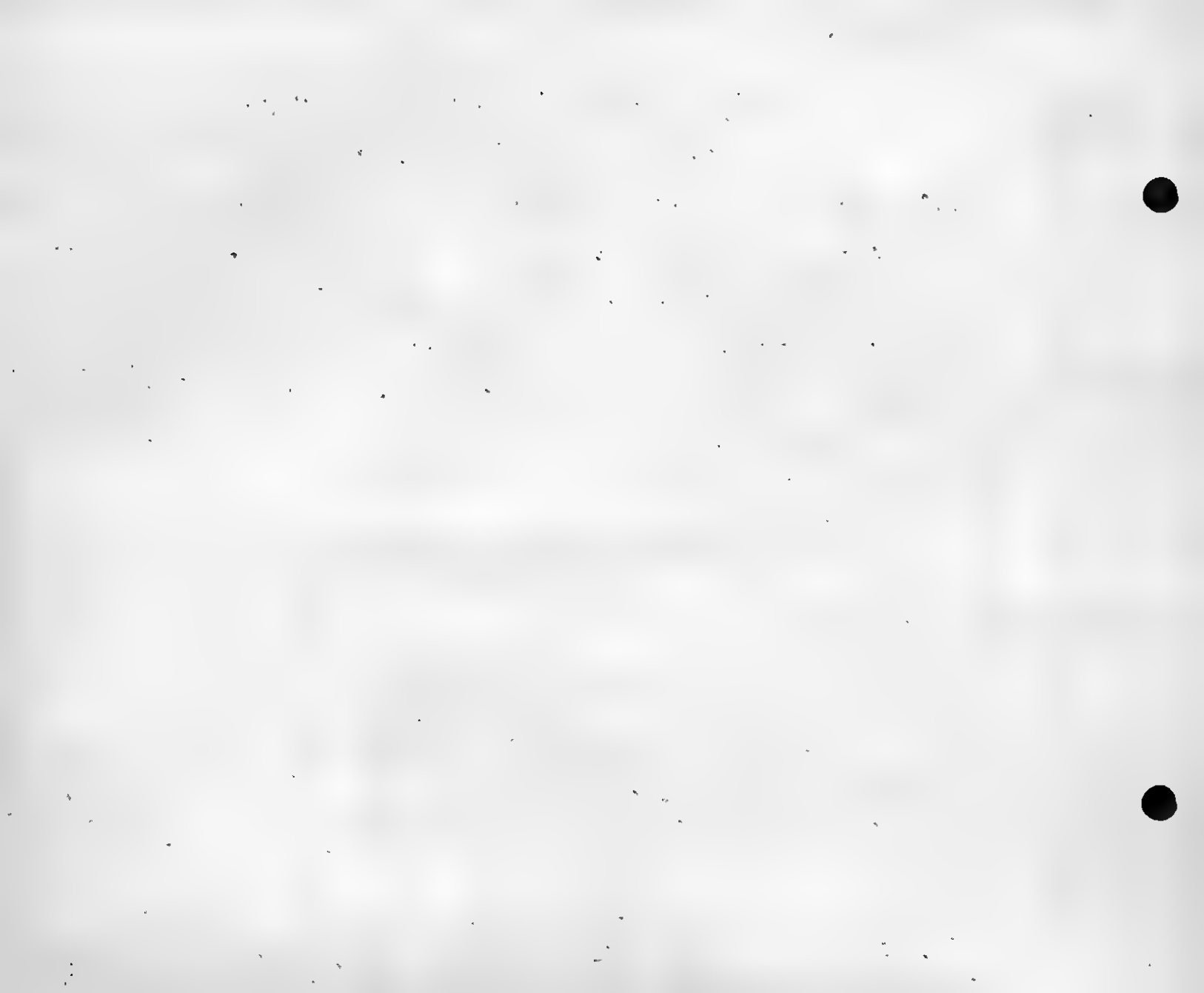
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) LAURA VIRGINIA LILLEY						2a. DATE OF DEATH Month APRIL Day 16 Year 1968			2b. HOUR M 		
3. SEX F		4. RACE W		5. DATE OF BIRTH DEC 1, 1882		6. AGE (In years last birthday) 85 YRS.		F UNDER 1 YEAR MONTHS DAYS 		F UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or fore'gn country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD					
10. CITY OR TOWN OF DEATH SAVAGE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 321 WOODWARD ST.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY HOWARD		13c. CITY OR TOWN SAVAGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 321 WOODWARD ST		
14. FATHER'S NAME First Middle Last JOSEPH ADREON				15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 		17. INFORMANT Address 321 WOODWARD ST SAVAGE MD HAZEL HEISHMAN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarct. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 x x x											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) 							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 		21f. LOCATION Street or R.F.D. No. City or Town SAVAGE County HOWARD State MD							
22a. I certify that (I) (this hospital) attended the deceased from April 1st, 1968 to April 16, 1968 , that (I) (we) last saw the deceased alive on April 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frank E. Shipley, M.D.				22c. DATE SIGNED 4/16/68		22d. PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D.		22e. ADDRESS Savage, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-19-68		23c. NAME OF CEMETERY OR CREMATORY Savage Cem		23d. LOCATION (City or Town) (County) (State) Savage Md					
24. FUNERAL DIRECTOR DeWitt Carson & Son				25a. REC'D BY REGISTRAR Charles Jones		25b. REGISTRAR'S SIGNATURE Charles Jones		DATE APR 23 1968			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) WILSON			First R.			Middle Pannell			Last		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 10-20-24		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Baltimore			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Howard		
10. CITY OR TOWN OF DEATH Jessup			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Paxtuxent Institution			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Howard			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3620 W. Garrison Avenue		
14. FATHER'S NAME Wilson Pannell Sr.			First Middle Last 			15. MOTHER'S MAIDEN NAME Gertrude Morris			First Middle Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO. 218-12-3837			17. INFORMANT William Pannell			ADDRESS 3620 Garrison Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Epilepsy											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) 											
DUE TO, OR AS A CONSEQUENCE OF											
(c) 											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
3533											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. 		City or Town 		County State 	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4-5-68		
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
4-5-68		Burial		Baltimore Nat Cent		Baltimore					
24. FUNERAL DIRECTOR Gray Wilson						25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
CHARLES MONROE PARHAM						ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			3:20 P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	May 31 1928	39 YRS.	MONTHS	DAYS	HOURS	MIN.	April 23 1968			3:20 P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			P Md.		
North Carolina		U.S.A.				Ap Howard					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last week or if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Woodstock		Lee Ramsburg Farm, Rt. 1		Bridgeworker		Construction					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET AND NUMBER		
Md.			Howard			Woodstock			Rt. 1 Lee Ramsburg Farm.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Dexter Parham			Martha Banham			no			218 20 2297		
17. INFORMANT			ADDRESS			17. INFORMANT			ADDRESS		
Vaughn Parham			706 Nottingham Rd. Balto, Md.			Vaughn Parham			706 Nottingham Rd. Balto, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Acute Acholism											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Fatty Liver											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				HOUR A.M. P.M.							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
ADDRESS (Street, city, town, or county)											
22b. DATE SIGNED				April 23, 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
burial				4/26/68				Church of God			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John R. Slack				Ellicott City, Md.				APR 29 1968			

04521

22722

1971

W. J. F. Smith